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M e m o r a n d u m

To: Seth Ellis, Administrator
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Date: May 21, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Motion Picture & Television Fund Skilled Nursing Units on March 7, 2012. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. While inquiring about the log of facility residents with pressure ulcers with the facility's Nurse Manager, the Operation Guardian's (OG) nurse was informed Resident 11-10-01 had a red discoloration to his right trochanter. The Nurse Manager indicated the facility was not sure what type of wound the resident had developed but stated the Nurse Practitioner had reported the wound to be a "deep tissue injury." The resident's right trochanter was observed by the team nurse, the team's medical consultant and the facility's Nurse Manager at the resident's bedside. It was evident from the observation the resident had developed a deep tissue injury. The right trochanter was observed with an approximate six centimeter reddened area with a dark purple blister to the center of the wound.

The resident was also observed with a pressure relieving boot applied to his left foot. The team nurse asked the Nurse Manager about the condition of the resident's left foot. The Nurse Manager reported the resident had developed a stage III pressure ulcer to his left heel after an injury which occurred when the wife took the resident out of the facility to a doctor's appointment. The resident apparently scraped the heel on the pavement when the transporter "dropped his leg while seated in the wheelchair and the foot dragged on the pavement." The team nurse inquired if the resident had on shoes when he went out of the facility. The Nurse Manager responded with *"I would think so."* The team nurse asked if an incident report had been completed regarding the injury and the Nurse Manager reported *"I assume so."* The resident's chart was reviewed by the team nurse and there was **no** documentation in the chart or computer records indicating there had been an injury to the resident's left heel while out of the facility. According to the nurses' notes, the resident was observed with a **left heel blister** on October 12, 2011.

The review of the resident's Care Plan showed there was no plan initiated for the deep tissue injury to the right trochanter observed by the facility staff on March 6, 2012. On March 7, 2012, an order was written for the resident to be placed on a Trivona bed mattress. The order was not specific to which type of Trivona mattress and it did not appear during the observation of the

resident's wound a specialty bed had been implemented. The facility's Nurse Manager reported the resident was diagnosed with Bullous Pemphigoid and due to this skin condition he would have episodes of blister-like nodules. The pressure wound on the resident's trochanter and heel were not related to his diagnosis but from continuous pressure.

It was evident the resident had acquired two pressure ulcers as a result of inadequate skilled nursing assessments and interventions for his care needs. Both of the pressure ulcers occurred at the facility due to the resident not being turned and repositioned frequently, not having an **appropriate pressure relieving mattress** in place, and not receiving diligent skin assessments. The resident required total assistance with his care and ADL needs and the facility had an inadequate Plan of Care in place to address his care needs.

2. The medical chart review of resident 11-10-02 indicated she had a history of a stage III pressure ulcer to her left buttock on December 12, 2011. On March 3, 2012 the facility noted a stage II pressure ulcer to the left buttock measuring 3.5 cm x 3.0 cm. The resident was ordered to have Exuderm applied every 72 hours. The resident was due for wound care on March 6, 2012 and according to the Medication Administration Record (MAR) the nurse did not administer the wound care as ordered because the area for the license nurse to initial the procedure on the MAR was blank.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1 West/1 East Unit

1. The residents' durable medical equipment i.e. wheelchairs and feeding pump poles were heavily soiled with dry food particles and required deep cleaning.

2. The Soiled Utility Room and Tub Room were observed with debris on the floor.

Harry's Haven

1. The Oxygen Room was unlocked and contained no oxygen supplies. The unlocked room was observed with loose cords dangling from the ceiling and unlocked and open doors to the electrical boxes. This is a severe safety issue for the residents residing in this memory impaired locked unit.

2. There was a glass vase, metal container and debris observed in an unlocked cabinet under a sink. This is a safety issue for the residents residing in this memory impaired locked unit.

3. There was peeling paint and wall paper in the residents' rooms throughout the unit. The beds were positioned against the walls of the room where the peeling mess had direct contact with the residents' bodies. This is a health and safety issue and requires immediate attention.

8. Room 21 was observed with a hole in the wall exposing the walls' foundation. This required immediate repair.

9. Room 24 was observed with an exposed night light bulb. The night light was plugged into the

electrical socket located above the resident's side of the bed. This exposed bulb was within the resident's reach. This is a safety issue for the resident. The room was also observed with curtains detached from the clips that held them on the drapery rods causing the drapes to hang down from the window.

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ADMINISTRATIVE OBSERVATIONS:

1. The medication refrigerator on the East/West Unit was unlocked. The licensed nurse had a difficult time locating a key that would lock the refrigerator. It appeared from this action the refrigerator was normally unlocked and this is not a safe practice. The manager should immediately address the issue with the licensed staff and implement the unit's policy and procedure.

2. Resident's personal supplies such as urinals were not identified with the resident's name. This is a health and safety issue.

3. The facility was unable to provide a pressure ulcer log book. The facility Nurse Manager reported she did not complete one and *"only identifies wounds by completing a wound care sheet that would be located in the resident's chart."* The team nurse again requested a list of residents with pressure ulcers. The manager then provided two resident charts she "thought might have current wounds."

STAFFING:

Based on the records provided by the facility, staffing levels was compliant with the 3.2 hours per resident day (hprd) on all six days randomly reviewed**.** The average hprd was 5.01 hours. However, it should be noted the facility did not provide time cards for registered nurses (RN) and it could not be determined if the facility was providing the required RN hours per Title 22 Regulations. It also then could not be determined if the licensed vocational nurses (LVN) were being appropriately supervised by a RN. Another issue identified was determining if any licensed nurse was in charge of the units. Included in the time sheets were detailed time cards for several persons not listed on the employee list and several time cards that listed abbreviations and codes on the sheet instead of an employee name. The codes did not correspond to the code sheet supplied by the facility that accompanied the staffing records.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Operation Guardians
Physician's Report
Kathryn Locatell, MD
May 21, 2012

Motion Picture and Television Fund
March 7, 2012

The two units licensed as nursing facilities were toured: the long term care unit housed in the same building as the acute care hospital and the dementia special care unit, Harry's Haven, located in its own building. Second-floor residents had been moved to the first floor the day prior to our inspection; the atmosphere was chaotic, disorganized. The facilities use electronic medical record as well as paper charts. There was a delay in gaining access to the EMR; one of the laptops provided for this purpose lacked the software needed to review it and had to be installed before review could proceed.

I reviewed the closed clinical records of three recently deceased residents. I examined one resident with a pressure sore, and in Harry's Haven, I examined one resident and reviewed the medication administration records for all residents. I found significant problems with the medical and nursing care being provided.

I. Medical provider services.

Care by the attending physician/medical director, nurse practitioner and consulting psychiatrist was reviewed. Deficient care, not in conformance with prevailing standards, was evident for each of the providers.

The medical director serves as attending physician for all of the residents in both units. This physician appears to lack basic knowledge concerning standards applicable to geriatric patients, nursing home residents and those receiving palliative or end of life care. His chart notes demonstrate that he does not coordinate care with other disciplines, including the nurse practitioner and nursing staff, or with residents' families. Review of resident medication regimens shows evidence of polypharmacy and unnecessary drug use, while the physician's notes fail to show that the indications, rationale, risks and benefits, and side effects potential have been adequately evaluated. There was a lack of coordination with the nurse practitioner, in particular.

For example, in the case of Resident 1, the nurse practitioner had discontinued one of her antihypertensive drugs a week prior to the physician visiting. The physician ordered an increase in the dose, which indicates that the doctor was unaware that the drug had been discontinued. Clearly, the doctor did not review recent orders written by the NP, a significant violation of the standard of care that potentially endangers patients. In the case of Resident 3, the physician ordered intramuscular injections of morphine for a dying resident (discussed further below). In a brief interview with the NP, when I

brought this order to her attention, she stated that she would have changed the order immediately, as she recognized it as inappropriate. However, this resident died before the order was changed. These two examples show that the NP and the doctor are treating residents in isolation from each other, which potentially leads to duplicative therapy, inappropriate prescribing and other dangerous outcomes.

Both the NP and the doctor are failing to establish goals of care with their patients. The establishment of patient-centered goals is critical in the practice of geriatric medicine. Each diagnosis, each drug prescribed, must be considered in light of the patient's age, prognosis and wishes, with risks and benefits of therapy clearly documented and reviewed with the resident and family. There is no evidence that the medical providers are practicing in conformance with these standards. Chart notes are devoid of meaningful evidence of a medical decision-making process.

Polypharmacy is a significant concern in this facility. Numerous residents are receiving in excess of 10 medications, some more than 20. Drugs to treat side effects of other drugs are added to the already-long list of medications these residents are burdened with, many of which are likely not benefiting the resident in any manner whatsoever. For example, resident L.G. was prescribed a drug to "treat" her orthostatic hypotension (blood pressure drops when assuming the upright position). However, the resident was receiving an antipsychotic agent known to cause this potentially dangerous adverse effect as well as three different medications to *lower* her blood pressure. Rather than conduct a careful evaluation for the medical necessity of each drug, another was simply added on.

Resident 3 was experiencing a rare and painful skin condition, bullous pemphigoid, in the months before her death. The condition results in the development of fluid-filled blisters in the skin all over the body which eventually rupture and resolve. In the elderly, the number one cause for this disease is an autoimmune response to a drug. Rather than systematically eliminate each drug in her regimen, the standard for management, the NP and physician embarked on a series of futile and painful topical treatments, including the application of a hydrogen peroxide solution directly to open blisters. The resident was clearly experiencing significant pain from the numerous blisters on her body, yet review of the NP's and doctor's chart notes shows that neither ever made a concerted effort to manage it. For example, in a visit note dated 11/1/11 (approx. four months before her death), the doctor wrote:

> *The patient has had generalized pain and has exquisite pain in her multiple ulcerated skin lesions over her body whenever she is given caregiving suggests [sic] personal hygiene needs and bathing.*

The physician did not document any review of her pain regimen, or of whether and when she received pain medicine, or of nursing staff's documentation regarding her pain other than to state, "I reviewed the [resident's] nurse's notes."

The doctor's assessment and plan reads as follows:

Bullous pemphigoid. Continue current treatment with glucocorticoids topically systemically [sic] and methotrexate. If a new lesion appears would reconsider treatment options.

The next note, by the NP on 11/15/11, likewise indicates no assessment of the resident's pain related to the bullous pemphigoid condition. At that time, the resident had also acquired a Stage 3 pressure ulcer of the coccyx area --there was no assessment of the resident's pain from this lesion either.

Resident 3, age 87 at that time, went on to experience a predictable decline to death over the next three months. There was a delay by both the doctor and the NP in recognizing the terminal nature of her condition; she was not given "palliative care" until one day before her death. This single case demonstrates numerous severe breaches which unquestionably harmed Resident 3.

II. Psychotropic medication practices.

The psychotropic medication practices in this facility are alarming. Drugs are added on top of drugs, with no documented indication, rationale, justification or discussion of risks and benefits. It does not appear that medical providers are obtaining informed consent before giving orders for antipsychotic drugs, antianxiety agents and "mood stabilizers" such as valproic acid (Depakote). For example, in Resident 3's case, the consulting Psychiatrist visited on 10/7/11 and noted that she was "described by staff as continuing to be very hostile and physically aggressive during care." The Psychiatrist's plan was to institute valproic acid therapy, with no discussion of its risks and benefits and no documentation that consent was obtained for the use of this potentially-harmful drug. Furthermore, considering that at that time, Resident 3 was suffering from skin blisters on her body—which clearly would have made routine nursing care very painful—the psychiatrist did not appear to have even considered that the resident's pain may have been causing or contributing to her hostility and aggression toward nursing staff. In addition, Resident 3 was already at that time receiving an antipsychotic drug at a moderately high dose, which the Psychiatrist even acknowledged had "no appreciable effect." The addition of valproic acid to her regimen constituted merely another chemical restraint and was unlikely to benefit her at all (and subsequent notations show that it did not).

The medication regimens of residents of Harry's Haven were remarkable for significant polypharmacy, including duplicative therapy in some instances with two different antipsychotic drugs. Review of behavior monitoring, completed by nursing staff, shows that nurses are not monitoring behavior at all, as their entries on the flowsheets consisted of illegible squiggles.

The case of resident W.K. was striking. He is 89 years old, and according to his medical record, "alert, oriented "x 3" with a normal score on a cognitive screening test." He has been treated with an antipsychotic drug for many years. There are no behaviors warranting the use of this drug documented in his record. He was observed at the lunch meal. His food tray, consisting of pureed foods and thickened liquids, was returned to the

cart untouched. He was known to suffer from dysphagia, prompting the dietary restrictions. There was no documented analysis regarding whether the antipsychotic drug, with a known side effect of dysphagia, might have been contributing to the resident's swallowing difficulties. The resident appeared thin, and told me he doesn't eat much of any of the food served because it is not palatable. He said he likes Chinese food and fresh, "crunchy" vegetables, which he is not allowed to have.

Among the residents of the dementia unit, at least half are receiving antipsychotic agents. Many are also receiving other drugs with psychoactive effects and/or side effects. For example, resident N.C., age 89 is currently receiving quetiapine (antipsychotic), donepezil and memantine (for dementia), valproic acid (anticonvulsant "mood stabilizer"), duloxetine (antidepressant and used for neuropathic pain) and gabapentin (anticonvulsant and used for neuropathic pain). Resident G.P., age 93, is receiving an antipsychotic drug, donepezil, oxcarbazepine (anticonvulsant), and pregabalin (for neuropathic pain. Resident E.M., age 91, is receiving two drugs for dementia, an antianxiety drug, and an antidepressant. Resident J.V., age 90, is also receiving two drugs to treat dementia as well as an anti-depressant. In my experience, such medication regimens are more likely to harm older elderly residents than help them. In addition to the burden of so many pills to take, residents may be experiencing side effects from receiving so many drugs in combination-- thus the risks and benefits of each need to be carefully considered and documented. The numerous prescribed medications also pose a financial burden on the facility, and also represent a very labor-intensive task for nurses: refilling, counting, stocking and administering them.

III. End of life care.

The "palliative care" practices in the facility are not in conformance with generally accepted standards of quality. As noted above, medical care providers are not developing goals of care with residents and families. A chart note might state, "now on palliative care," yet little to nothing in the resident's treatment regimen has changed beyond the addition of an opiate analgesic.

Resident 1, suffering from "vascular dementia with psychosis", experienced a decline in her condition after "multiple units to the acute care unit" for treatment of congestive heart failure, lung infections, urinary tract infections and fractures. She was sent to the acute care unit in December for an episode of chest pain, and on return to the long term care unit, her family requested "comfort measures only, no aggressive treatment, no transfer to acute care for any events. Palliative Care Service was called and reinstituted," according to the discharge summary. Over the next two months, medical providers continued to prescribe numerous drugs for blood pressure control, an antipsychotic agent, an antidepressant and other drugs of questionable value in this resident's case. The NP and physician continued to order laboratory tests, antibiotics, and other disease-directed therapy until late in her course, making it difficult to discern what exactly the providers thought constituted palliative care. Social services contributions to enhancing the resident's psychosocial experience was limited; the most recent note prior to her death references providing the resident with a letter and "the press release" regarding re-

opening of the long term care unit. The social worker did not evidence any awareness in his documentation that the resident was dying.

The medical providers in the facility appear to lack knowledge of the basics of palliative care for the dying person. One glaring deficiency was the failure to provide medications for symptom relief on a proactive basis. Orders for opiate analgesia, for example; were limited to a single dose and time frame rather than a range. As noted above, the physician ordered intramuscular morphine for a resident on the day she died, having observed that she was in "breakthrough" pain despite the orders given by the NP the day prior; the NP had ordered a fixed dose at a fixed time interval with no options for the nursing staff to titrate upwards to symptom relief. The ability to titrate drugs to maintain symptom relief, on a continuous basis, is critical to providing good nursing care at the end of life, yet neither the NP nor the doctor demonstrated any knowledge of this basic standard in the three recent deaths I reviewed.

The standard for hospice-type palliative care of the dying person also dictates that drugs are given by the least invasive route possible. Many, if not all of the medications used to enhance comfort for dying persons can be given orally, with concentrated solutions that can easily be increased in dose and frequency as needed, and also offer the advantage of almost-immediate absorption though the oral mucous membranes. However, in the three recent deaths reviewed, the providers prescribed only injections of opiate drugs. The piercing of the skin with a needle is painful, needlessly painful considering that it's seldom if ever necessary in patients such as the residents reviewed. Intramuscular injections are equally painful and are rarely if ever used in hospice care.

The lack of a multidisciplinary approach to the dying resident was also notable in these records. The facility claims to be providing a specialized palliative care service, but without these elements, all that remains is a medical model dictated by the NP and doctor.

IV. Nursing services.

Two residents recently acquired full-thickness pressure ulcers. On the day of our inspection, Resident A was noted in the nursing communication log to have a "pressure site" on his right hip that was "still red." Inspection of this wound revealed a severe, recent deep tissue injury. The skin over the right greater trochanter (bony prominence) was deep red to purple, with evidence of blistering, in a circular lesion of approximately 6 cm in diameter. The only possible cause for this pressure sore was that the resident was left in the right side-lying position for many hours, at least 12, without being repositioned at all. I consider the development of this wound to be a clear indicator of nursing neglect.

In summary, systemic problems with the provision of medical care and services, with extreme polypharmacy and the unwarranted prescription of psychoactive agents without adequate indications or consent, create a risk of possible substantial harm to every resident of the facility. When residents reach the dying stage, care is definitely not in conformance with prevailing standards and residents are needlessly suffering as they die.